PTSD 101
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COURSE TRANSCRIPT FOR:
Group Therapy for PTSD: Issues & Answers
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Slide 1: Group Therapy for PTSD: Issues & Answers

Hi my name is Dr. Shirley Glynn. I'm a clinical research psychologist at the West Los Angeles VA Medical Center. I have been working in the field of PTSD for about the past fifteen years. I was the supervisor on the biggest national trial of group treatment for PTSD and I also have run a couple of clinical trials doing exposure with PTSD and family therapy with PTSD.

Today, we're going to cover group therapy for PTSD, try to cover some of the basic issues as well as some of the current controversies. Most of the information we have for this population involves more chronically traumatized people. So although we'll be addressing issues for more recent survivors such as people from national disasters or OEF or OIF veterans, we really have much less information about that so, we'll just be trying to provide the best guidance we can, based on what we know right now.

Slide 2: Collaborators on the Project

I am going to also be acknowledging my collaborators on this talk. I have been working for the past probably seven or eight years now, with a number of investigators throughout the country who are also clinicians at the VA who have done work with other kinds of PTSD as well, and have been particularly working on group treatment models for PTSD.

Slide 3: Overview of Presentation

Today I'll be talking on a number of different topics. We'll be discussing the epidemiology of PTSD as well as the history of group treatment for PTSD. I'll briefly cover research findings on group treatment for PTSD as well as covering different kinds of group therapy you might consider for someone dealing with PTSD, and then I'll be talking about three kinds of groups. I'll be talking about more introductory groups, which involve typically psychoeducation and skills training and then two more intensive kinds of groups, Trauma-Focused group treatments, and we'll be talking about the rationale and the components of that, and then Present-Centered group treatment and the rationale and components of that. And then finally, as I said, we will revisit the concept of recently traumatized survivors and see what we can glean to help them.

Slide 4: PTSD is Among the Most Prevalent of Psychiatric Disorders

Briefly I want to talk about the epidemiology of PTSD. As you're probably aware this is one of the prevalent disorders, psychiatric disorders, when you do epidemiological studies prevalence ranges from five to ten percent of community samples. And of course, it's higher when you first confirm exposure to a Criterion A stressor; so if you go into a group of people where there's been a natural disaster, or you know that they have an assault history, or they've been exposed to community violence.

Slide 5: PTSD May be a Common Outcome of Terrorism

Now if we think about times when groups tend to be exposed to PTSD, it is often the time we think about group interventions, particularly when we talk about recent trauma survivors. If we think about things like terrorism, natural disasters or war we find that epidemiological surveys tend to indicate there are relatively high rates of PTSD in folks exposed to these kinds of events. For example, you may see that close to 10 percent of the people in an Israeli sample of people who had been exposed to a traumatic event consequently develop PTSD. And after 9/11, a random digit dialing study found that approximately 7.5 percent of the sample appears to have acute PTSD one month after exposure to the 9/11 trauma in New York.

Slide 6: PTSD is a Common Outcome of Natural Disasters

If we think about national natural disasters, there was recently a really well done epidemiological research survey by Galea et al., that looked at all of the reported prevalence from 1980 to 2003 for PTSD after natural disasters and found a wide range of prevalence, 5 to 60 percent, but higher rates with people who were either clinical samples, or were in areas heavily effected by the disaster-- so actually had more severe exposure.

Slide 7: PTSD is a Common Outcome of Combat Exposure

Think about combat. It will come as no surprise to most people that exposure to combat tends to be related to high rates of PTSD. This was, surely you can read reports from the Civil War and even the Revolutionary War with people talking about how they were traumatized by war. This has been more systematically studied in the past twenty-five years. And for example the NVVRS study of Vietnam veterans found that a third of the veterans had had PTSD at some point since the war and a half of those still had current PTSD when they were assessed. There are similar high rates with Gulf War veterans, ten percent reporting PTSD.

Slide 8: PTSD is a Common Outcome of Combat Exposure (cont.)

And finally, if we look to more recent combat exposures, Litz did work with peacekeepers in Somalia and found about 8 percent reported symptoms consistent with the diagnosis of PTSD. And of course we're all aware that there are more and more studies coming out of OEF and OIF veterans. Although there is some controversy about what the levels of PTSD are and what the level was before people actually went into the service, it certainly seems to be the case that

there's a prevalence rate of at least 6 to 12 percent with people who did serve in a combat zone and higher rates with people who saw more exposure.

Slide 9: Effective Treatments for PTSD are Available

Now if we think about effective treatments for PTSD-- of what we've learned over the past twenty-five years or so, there are a number of effective treatments. These tend to be more behaviorally based-- although not exclusively. And they also tend to be primarily done with individual formats. So the information is enlightening for group treatment, but not fully explanatory. If we think of recent surveys or meta-analyses, one by Bisson and Andrew just came out last year-- that's a Cochran report if you want to seek it out. Generally, they find that treatment is effective compared to a waiting list control-- most active treatment is. And behavioral treatments may be a tad better. And generally, there are improvements at end of treatment and at follow-up.

Slide 10: Little Data to Suggest Which Treatments are Optimal

We don't know which treatments are better for which individuals. The nature of the research at this point doesn't allow us to match treatments with individuals nor does it permit us to know with certainty that one treatment is better then another. You may be aware there are numerous kinds of behavioral treatments. There are also some that include cognitive components. There is stress inoculation training. There are even some developmentally informed interventions. And it's really hard to know at this point whether any one is consistently better than the other, although the behavioral treatments tend to have the strongest research support. What we would say is some treatments can typically only be done individually while other treatments can be done in a group, for example cognitive-processing therapy would be, or exposure would be, an example of that. Then some treatments such as group process treatment groups are only done in a group setting.

Slide 11: Little Data to Suggest Which Treatments are Optimal (cont.)

One question about people with chronic PTSD is trying to determine how much treatment is enough, and here we don't know. Dose is an issue. Many people going into a treatment setting, particularly at a place like the VA,and may qualify for many groups. We don't really know at this point if more treatment is better. In fact, we did a study here at West LA where we gave people exposure; people could be randomized to exposure and family treatment or just exposure. And although there was a trend for the family treatment providing better outcomes, it wasn't statistically significant. It may in fact be that during any course of time, people can only change so much.

Slide 12: Group Treatment for Combat-related Trauma

Okay I'm now going to talk a little bit more specifically about group treatment. The ideology of group treatments for PTSD really has come out of the Vietnam War. If we talk about the history of that we know that there was an informal rap group movement in the late sixties and early seventies (before there was even a diagnosis of PTSD) that, in fact, was kind of a "brothers

helping brothers" approach, not professional. This was before there was even a diagnosis of PTSD so there wasn't talk about cure, but there was a thought of helping people get re-socialized. Unfortunately, we don't know really know how effective these kinds of groups are.

Slide 13: Group Treatment for Combat-related Trauma (cont.)

The VA in the late seventies began to codify these sorts of groups-- primarily in Vet Centers. And after the recognition of PTSD as its own diagnosis in the 1980's, there was even more of an effort by the VA to start getting professionally led groups up and going, run by psychologists, social workers, psychiatrists and other mental health professionals, to try to coordinate and treat veterans.

Slide 14: Why Group Therapy?

When you think about why a group treatment might be particularly useful for a traumatized sample, the kinds of thing you might think about is that certainly there can be resource efficiency if the group is large enough. It's an opportunity to provide social support. We know of course that PTSD is a disorder of avoidance and this is a way for people to begin to get re-integrated into the community. Some groups can be "open" so if folks can't make a commitment in an ongoing way to a therapy experience, they still may be able to come in occasionally and be socialized into it. They get feedback from peers. It can compensate for the problem that many professionals working in the field, many mental health professionals, don't have share the trauma background of the survivors, and thus or maybe discredited by the survivors seeking treatment. This is a way to use the expertise of the mental health professional *and* the expertise of other people in the group.

Slide 15: no title

Briefly, there are six randomized controlled trials of group treatment for PTSD. You'll see them listed here….[contained on the next series of slides].

Slide 16: Studies of Group Psychotherapy for Trauma Survivors: Cognitive-Behavioral, Psychodynamic, and Supportive Types

These are mostly done with child sexual abuse survivors and sexual abuse survivors of adult assaults. What you'll see in the next four slides, going over the research, is that generally the designs involved folks being randomized to an active treatment or a wait list. And that in fact, the active treatment, typically involved group treatment for PTSD as well as some other sorts of things, [for example their] might be writing, or groups might be combined with individual sessions. Generally, there was a trend for the group, the active group treatment, to be better than the wait- list treatment in all six of these studies. The largest study of these is the one done by Schnurr with Vietnam veterans. I'm going to go into more detail about that study because it is the largest one, and because it has special relevance to many people working with combat survivors.

Slide 17: Studies of Group Psychotherapy for Trauma Survivors: Cognitive-Behavioral, Psychodynamic, and Supportive Types

No audio, studies listed in tables.

Slide 18: RCTs of Group Psychotherapy for Trauma Survivors

No audio, studies listed in tables.

Slide 19: of Group Psychotherapy for Trauma Survivors (cont.)

No audio, studies listed in tables.

Slide 20: of Group Psychotherapy for Trauma Survivors (cont.)

No audio, studies listed in tables.

Slide 21: VA Cooperative Studies #420 Group Treatment of PTSD

So now, I want to speak briefly about the largest group treatment randomized control trial of PTSD that was done by the VA. It was published a few years ago. The principal investigators were Matt Friedman and Paula Schnurr and I was the supervisor for the exposure-based treatment in this study.

Slide 22: Questions

It was a study done with three hundred and sixty Vietnam vets. The question was, "Is Trauma-Focused group treatment more effective than present-centered group treatment for treating PTSD symptoms?" Of course, there were secondary questions about whether we would get improvements on physical health and functional outcomes.

Slide 23: Clinical, Training and Administrative Sites

[Map of US showing regions where study took place]. As you can see, it was done in 10 sites throughout the country from the East to the West Coast. And the training centers were in Boston, Providence, and West LA.

Slide 24: Participants

As you'll see, the participants were three hundred and sixty Vietnam vets. This was done in the mid-nineties so they had chronic PTSD, many for twenty or thirty years. They were randomized to either Trauma-Focused group treatment or Present-Centered group treatment.

Slide 25: Participants

As you'll see, there were the ten sites, each ran three cohorts with six men in each group, so it would be twelve men total in each cohort.

Slide 26: Inclusion and Exclusion Criteria

We tried to make the inclusion-exclusion criteria broad. It was men with PTSD but they did not have to be totally clean of substances; they just had to agree to try to work on being clean and sober and to terminate other therapy while they were doing the treatment. And we excluded people primarily with psychotic disorders.

Slide 27: Implications of Liberal Inclusion/Exclusion Criteria

I think researchers would think of this as broad inclusion criteria, although most clinicians would probably think this as rather limited because people had to at least say they would work on their substance use and not be in another treatment. But of course, some of these treatments are stimulating and it's hard to work with people with very active severe substance abuse problems in more intensive treatment.

Slide 28: Baseline Description of 325 Male Veterans Who Participated in at Lease 1 Follow-up Assessment at 7 or 12 months

If you look just briefly these were men in their fifties. Many had service connection. About half were married.

Slide 29: Baseline Description of 325 Male Veterans Who Participated in at Least 1 Follow-up Assessment at 7 or 12 months (cont.)

Again, many had service connection and many had co-occurring mood and anxiety disorders.

Slide 30: Procedure

Looking at how people went through the protocol-- they were screened. They then waited until there were enough people for a group and then all had their assessments. There was thirty weeks of treatment; either Trauma-Focused or Present-Centered. They then had an second assessment. There were five months of booster sessions and then additional assessments.

Slide 31: Therapy Format

The groups were made of five to six veterans randomly assigned to one of the treatments. There were two co-therapists and sessions were ninety minutes. It was a year of treatment. The data indicated that the treatments were delivered well by the clinicians throughout the VA sites.

Slide 32: Description of the Two Treatments

I'm going to talk about the two treatments in more detail in the later part of this talk. Briefly one is Trauma-Focused group treatment, which I consider supported approach behavior. It involves

in-session and home-based exposure, and skills training. And there was Present-Centered group treatment, which involved a "here and now" approach, with a particular emphasis on not talking about the trauma.

Slide 33: Treatment Protocol

As you'll see, everyone in the protocol had a [PTSD] diagnosis and received case management in the group therapy. They could also attend twelve step programs.

Slide 34: Example of CM Activities

People did get case management and one thing I would encourage you to do, particularly if you're doing more intensive groups, is to assure that people have somewhere where they can get case management because the more intensive work in these kinds of protocols, involves people actually coming in and being able to concentrate on whatever material is being done that day. Of course, if somebody has a very serious medical problem, or their homeless, or they've been arrested--they're too distracted to work and you really want to be able to tell people that they can talk with their case manager about that and then they can focus on the group right now.

Slide 35: Major Findings: CSP 420

The major findings, there's really three major findings in this study. First of all, there was differential dropout. It was harder to get people to stay in the exposure group. There was a 10 percent greater dropout in the Trauma-Focused treatment. In an intend-to-treat analysis, both groups got better and there was not a difference between the two groups.

Slide 36: CAPS TOTAL SCORES DURING ACTIVE TX (Intent to treat)

You'll see that depicted here on that graph that both groups are going down. There is no difference at month seven or month twelve on the group differences. In both groups there is a time effect, however.

Slide 37: Major Findings: CSP 420

So the major finding is that both groups were effective. But we also have the issue about trying to see if, in fact, the people who attended the group more, who actually got the exposure, if they would in fact get more benefits. So, in the next analysis we looked at that.

Slide 38: CAPS Total Scores During Active Treatment (Adequate exposure)

What in fact we found is a marginal trend, $p<.06$, that if people stayed in the exposure, in the Trauma-Focused group treatment, they tended to do a little better than the people who stayed with the Present-Centered group therapy. But again, this is only people who attended at least twenty-four or more sessions, which was about two thirds of the sample.

Slide 39: Summary: CSP 420

So the summary is: the two group treatments could be delivered with fidelity. Both treatments appeared effective, but the Trauma-Focused group treatment maybe more difficult to tolerate. But if people can get through it, they may do a little better.

Slide 40: no title

So now, if we take the data suggesting that this is an effective treatment, I'm now going to quickly talk about the three kinds of treatments we might think about.

Slide 41: Advantages of Single vs. Group Treatment Formats

Okay if we're talking about group treatment there are advantages to group treatment. It can be more economical, [provide more] social support, and be less vulnerable to staff turnover if it's a co-led group. But there are advantages to single format. Sometimes it's easier to get people in, schedule people, and appointments can be more flexible. It can be easier to engage the person in the program.

Slide 42: Two Types of Groups

We see that there are two types of groups. There are shorter psychoeducational skills groups. These groups are often good for orientation and engaging people in the system. And then there are more intensive therapy groups.

Slide 43: Putting Together a Group

When you're thinking of putting together a group, regardless of the kind of group you're talking about, you want to be thinking about that you want some diversity but some cohesion. Yalom's book is very good on group therapy-- talking about how you don't want anyone in the group who is different from everybody else. So you wouldn't really want a group with five men and one woman, or five African Americans and one Asian. I mean you want at least two people in each group who are similar to each other. You want to develop a sense of safety and work on developing a group community.

Slide 44: Group Management

So you want to set expectations for appropriate group behavior that can involve the orientation sessions before the group, phone calls between sessions, or meetings before and after the [group] meeting. Although there's controversy about this, we firmly believe that you should think carefully about who can fit into your group. If it appears that someone is having difficulty joining the group, it's okay if he's given multiple attempts, to try to socialize them, or to ask them to leave because this would not be the best therapeutic opportunity for them. This can also create havoc with the group.

Slide 45: Starting with Skills Group

Again we talked about starting with skills groups for orientation. These may involve a commitment of just a few months and they permit the opportunity to be socialized, with being with others, without having too much being asked of you.

Slide 46: Benefits of Skills Groups

The benefits of skills groups. If we think of how trauma leads to PTSD and then psychosocial deficits, skills groups can help compensate for those deficits, which then is the foundation for more intensive groups and successful management of symptoms.

Slide 47: Psychoeducation/Skills Group Format

If we think about psychoeducational skills groups, as I said, they tend to be short. Group members can be invited to participate but aren't required. There are modest expectations, things like regular attendance or confidentiality. [These] are typically done in a cohort.

Slide 48: Characteristics of Skills Groups

As I said, these tend to be non-threatening groups [participation is voluntary but] sometimes you can even have members of the group come back. They may rotate through the group a couple of times, for example through an anger management group or a psychoeducation group. So there can be old members and new members to encourage continuity.

Slide 49: Group Format

[For a] typical group, as I said, the group format might be eight weeks, or ten weeks, typically around a [specific] topic.

Slide 50: no title

Topics might be things like understanding PTSD, stress management, wellness, mindfulness, anger management-- the kinds of building blocks that people would need to do more intensive trauma work down the road. If somebody has a problem with anger such that they get out of control, you really want to handle that before, help them handle that before they go into exposure. If somebody has serious health problems, such that their health is very compromised and precludes them from really being in a more intensive group, you want to help them work on that in a wellness group, before they go into more intensive work.

Slide 51: Preparing for Intensive Groups

Intensive groups. Here we'll be talking about Trauma-Focused group treatment and Present-Centered treatment. Generally, we believe that you should do individual screening of group members because not everybody is right for a group. The kinds of characteristics you're looking for are: somebody who is capable of attending to other people, sees value in working with other

people, has some stability in their lives so they wouldn't come into every meeting needing case management, and somebody who is not actively using substances, or they're trying to reduce so that even if they're not willing to be abstinent, that they're willing to make a commitment. They're not going to leave a session and get drunk. Again, it's important for the therapist to set expectations for appropriate group behavior. One of the ways to do that is using the Socratic method and asking people, "What kind of guidelines do we need in this room to make it feel safe for people?" You often find the participants come up with things like confidentiality, being on time, regular attendance, all of the kinds of things that we would want.

Slide 52: Preparing for Intensive Groups (cont.)

We can also anticipate that people will have resistance to being in a group and one of the ways to deal with that is to anticipate resistance. So talk with people either individually or in that first group session about: What can get in the way of attendance. Let's problem solve that. What can get in the way of homework? Let's problem solve that. What will you do when you feel discouraged? And what will you do if other people think you shouldn't be in this group? Again, if you see obstacles in this arena, you may want to resort to having someone work again in an orientation or skills group.

Slide 53: Engage Family Members to Support Participation of Traumatized Members in Treatment

Some people have family members who are very concerned for them and it can be helpful to have a family meeting with the family before someone goes into a group, particularly if they're going to do intensive exposure work. [This meeting is] to try to explain that this is going to be intensive and it might get a little worse before it gets a little better. It's kind of… I always use the analogy of heart surgery. It's sort of like having a bypass. You feel really bad for six weeks but in six months you feel much better. So that family members and support people understand that the survivor is now undergoing an arduous task and can use some assistance.

Slide 54: Trauma Focused Therapy

The two kinds of more intensive groups that we talk about, the first of these is Trauma-Focused group therapy. For those of you who are familiar with exposure therapy, it's essentially exposure therapy done in a group

Slide 55: no title

This is a cute little slide about what can happen if you're doing Trauma-Focused group treatment and you don't have the skills, you might find out that you're the only one left in the group. And this can happen. So one of the things it's important to do is really make sure your skills are sharp and that you've obtained the supervision and training you need if you're going to embark upon this.

Slide 56: Overview of Trauma-Focused Group Therapy (TFGT)

We're going to discuss now how these groups can range in length. We have done protocols from sixteen to thirty sessions but regardless of length these are the key components. You use a learning base framework. You focus on extensive exposure, it's happening in the session and outside the session. It typically involves coping skills as well. It involves a developmental view. So people think of who they were before the trauma, during the trauma, and after the trauma, which helps them integrate it into their lives. As we said it needs to be embedded in customary care with case management.

Slide 57: Functions of Case Management

…and the kinds of things that case management might involve are helping with compliance issues, helping with housing issues, helping coordinate information with the treatment team.

Slide 58: 1) TFGT Incorporates

Trauma-Focused group treatment incorporates these three things, exposure therapy, cognitive restructuring after the exposure therapy, and coping skills development.

Slide 59: 2) Rationale for Using TFGT with Trauma Survivors

If you think about what would be a rationale for using Trauma-Focused group treatment with survivors, one of the things with trauma survivors is that they feel bombarded by the past. This is a way to approach the past in sort of an assertive way, that instead of it coming to you as flashbacks, you're actually going to pick a time and talk about it and get a sense of what happened to you, and how you understand it, how it changed you, and what you can learn from it. We also teach coping skills. We want to reduce symptoms and we want to help people get back, reintegrated into the community.

Slide 60: 3) Detailed Description of Major Treatment Elements

That covers the typical treatment components and as I said we'll [now] discuss the specific format. The one I'll be talking about today here is a twenty-session approach, but it can vary depending upon the size of the group and what you need to do. [We will talk about] coping skills, exposure therapy, and relapse.

Slide 61: TFGT Format Options

A typical group would be two therapists meeting for twenty sessions with five to six clients, that way the group can go on even if a therapist isn't there. An alternative format is to have one therapist in fewer sessions, with people doing more exposure out of the group, rather then in the group. We prefer to use two therapists and have a longer duration so everyone has two full sessions devoted to work on their trauma.

Slide 62: TFGT Format

A typical session involves check-in, the actual activity for this session whether it's exposure or skills training, and then checkout. So everybody has a chance to sort of get back down to a baseline and ground before they leave the session.

Slide 63: Session 1: Introduction and Education

The first session might typically include the rationale for the intervention. You need to get people on board and understand what the rationale is. It maybe very counterintuitive because they may have spent their entire life trying to avoid things, and now we're saying come in and face it. [It also involves] education, discussion about check-in and checkout, and describing SUDS (which is essentially getting a zero to ten rating of how distressed the person is). You can also use [SUDS] that information during exposure. And finally, identifying group guidelines and homework.

Slide 64: CBT for PTSD: Education about PTSD

These are the kinds of things we talk about with education, which essentially is providing [information to] normalize experiences.

Slide 65: Session 2: Coping Skills and Resources

The second session involves coping skills. We want people to have a lot of skills before they go into the exposure. This involves relaxation, stopping, those kinds of things.

Slide 66: Coping Resources Self-Assessment

We actually have people do a formal assessment of their coping skills and then work on areas where they have deficiencies. We provide recommendations for that in the session.

Slide 67: Session 3 and 4: Building

We do scene-building. The notion is that each person who is going to do exposure is going to have one scene that they are going to go over in minute detail during the rest of the work in the group. Many people only have one scene, for example they had been through an earthquake or a hurricane. Other people, if they've been in combat or been sexually assaulted multiple times, will have many scenes. Your job in these sessions is to reinforce and depict the one that has the most impact on the person. Help them choose, if they have multiple scenes, by using SUDS for how upset they get when they talk about them.

Slide 68: Exposure Therapy: Scene Construction Principles

Then we do exposure therapy. After they've picked their scene, they are now going to develop about a forty-five minute narrative of the scene. It can be shorter, in which case you'll do it twice in the session (if it were only twenty to thirty minutes). If it were longer, it could be done once in a session. It's going to have three acts, what happened before, what happened actually during the session… during the event, and then what happened afterwards.

Slide 69: Sessions 5-16: Trauma Focus Scenes

We do the exposure based on the person's personal trauma experience. Half of this session will be spent on them recounting their event. The other half will be spent on cognitive restructuring about that event. Information and opinions of other group members are elicited. Then there'll be homework. Each person has the opportunity to have two full sessions, not done consecutively, about his or her trauma.

Slide 70: TGFT Exposure Session General Guide

SUDS are elicited at each phase, as we said, at the beginning, while they're doing their exposure, and then afterwards.

Slide 71: Exposure Session Check-In

If you're starting in with check-in, you can go to SUDS and then ask, "Are you ready to work today?" and [if so] then start.

Slide 72: Exposure Session

In trauma exposure what you want to do is use the present tense so that [it is as if] people are in the event here and now. So: I'm walking down the street. I'm walking to the door. I'm driving in my car. I'm hearing. I'm seeing. I'm knowing. You want to use the present tense and use all senses. Other members are supposed to pay attention because they'll be giving feedback.

Slide 73: Exposure Session (cont.)

Once the exposure is done, the typical thirty to forty minute exposure of the scene, the other group members are asked to identify any data that suggests that the person misunderstands what happened. Perhaps they see themselves as culpable when they were not, or that an event is controllable when it was not. Other members can be very important in giving this kind of feedback.

Slide 74: Exposure Sessions Check-out

And then there's checkout, which essentially [involves] everybody in the group completing a SUDS and saying how they're doing, and plans are made for the future.

Slide 75: Exposure Homework

Trauma-Focused group therapy is a cognitive-behavioral treatment and as such, there is a large emphasis on work on using skills outside of the session, and doing homework, to make sure the activities in the session actually promote change. For the Trauma-Focused group treatment exposure we're talking about here, the primary homework involves [the person] listening to the audiotape of his of her narrative that they do in the session, and to listen to that tape weekly as

the exposure sessions continue. If you recall, the trauma focus exposure sessions involve twelve sessions where participants are actually narrating and describing their traumatic events.

Typically each person would do one in the first six sessions of the trauma focus work and then a second recollection in the second six sessions of the trauma work. When they leave the session they're given a tape of the work they did in that session. So it is audiotaped, both their narrative and the cognitive feedback from other participants. They're given a homework assignment to listen to that tape at least weekly through the end of the therapy. After their second recalling of the event in session they're given that tape to listen to, to replace the earlier tape. If participants listen each week to the tape that they made in the session they should have two sessions in the actual groups and ten sessions outside of the groups yielding a total of twelve sessions, twelve trials of exposure to the narrative event. That should be sufficient to exposure to reduce PTSD symptoms.

We really encourage facilitators to do everything they can in terms of problem solving with people to make sure that they're able to listen to the tapes of their sessions at least weekly. In addition we encourage people to listen to the tapes in a quiet place where they can reflect on the work, perhaps journal and talk a little bit about what it was like so they can bring that into the next session. And we encourage them not to listen to it with other people unless they have thought through the consequences of doing so. Some people want to listen to the tape with family members, but we always want people to think through the consequences of that and what they anticipate their family members might think about the event that they're retelling. In any case, our ultimate goal is to have a total of twelve sessions of exposure to the narrative events.

Slide 76: Session 17: Social Support

The final four sessions of the group involve, first of all, social support… a session on social support.

Slide 77: Session 18: Anger Management

A session then on anger management…

Slide 78: Session 19: Relapse Prevention

A session on relapse prevention…

Slide 79: Session 20: Summarization and Termination

And finally a session on summarization and termination.

Slide 80: Indications/Contraindications for Assigning Clients to TFGT

I want to talk briefly about selecting patients for Trauma-Focused work. You really want people who understand the rationale for the treatment. They're willing to do the exposure. They have to be willing to tolerate distress without acting in destructive ways. That's why they may need

the earlier work on substance use or anger management, and they need to have comorbidities under control. They should not be anticipating major life crisis. This is not the kind of treatment you would want to start if somebody were having heart surgery in two months.

Slide 81: Therapist Issues, Experience and Training for TFGT Competence

Therapists, if we think about what they need--they need to have processed their own traumatic events, understand CBT, and if they're inexperienced, they need need assistance from, supervision from, a good clinician.

Slide 82: Critical Skills for Delivering/Managing TFGT

The kinds of skills this [type of] therapist needs. They really need to be able to do the CBT and sit with it and keep on board.

Slide 83:

Now I'll briefly talk about Present-Centered group treatment.

Slide 84: Present-Centered Group Therapy

This is more of a process group model, using Yalom's material and consistent with schema theory. So essentially, what you have is someone who is stuck in the past and you're going to push them into being in the present.

Slide 85: Overview of Present-Centered Group Therapy (PCGT)

The typical overview involves your focusing on present issues. You're focusing away from the trauma and you're trying to move the mental state from the past to the present.

Slide 86: PCGT Features

There's a low to moderate level of confrontation. Structure is secondary to process, but it is important. Transference is minimized and you don't assign a lot of homework.

Slide 87: PCGT Characteristics

There is active leadership, low to moderate structure, emphasizing strengths. Mid-range affects so that people aren't getting too upset or too bored.

Slide 88: Schema Theory

I'm briefly going to review this. You can look at the slides. Essentially much of this work is embedded in schema theory. The notion there is that schemas are sets of beliefs that we have with us that are based on our learning history and that we are active perceivers in our lives. And whenever we get new information we're looking at that information within the prism of the

schemas we have. So if we have grown up to believe it's not a very trustworthy world and there is an ambiguous thing like a person gives a grimace and we can't tell if they're smiling or not smiling at us we might be more likely to think they're not smiling, they're not trustworthy. All right, it's an active process between what we've learned in the past and what's going on in the present.

Slide 89: Cognitive Schemas (cont.)

And that in fact what's happening in trauma work is, that what we need to do is, we need to get people to move from the past into the present and to be thinking about the new information as a possible way to change the schema rather than to keep the same old belief systems.

Slide 90: Schema Theory and Trauma

As I said, in trauma the notion is that the present, the present is sort of violated. People stay in the past, and the give and take between changing sets of beliefs and experience does not occur.

Slide 91: Disruption of Schema by Trauma

This continues even though the trauma may have been fifteen or twenty years ago that the triggers that the current information continues to provoke those old beliefs.

Slide 92: Schema and PCGT

The notion of present-centered group treatment is that it's a way to change those schemas and give people the opportunity to get new information because they have made a contract with the group therapist to stay in the present and not be completely overrun by past beliefs.

Slide 93: Schema Changes with PCGT

And once that happens in a group, there may be greater responsiveness to current information, greater flexibility, and greater investment in everyday life, all of the positive things we'd be looking for in participation in this group.

Slide 94: Rationale for Using PCGT with Trauma Survivors

The rationale for using present-centered treatment with trauma survivors is, as I said, the primary one is to move people from the past to the present.

Slide 95: Typical "Roles" Seen in Group Members

Now in the typical group, people may take on roles, as we know. They may be victims, or twins, or they may take on the role of helper. And so the clinician wants to be attentive to that and try not to let people stay in these roles because it's a way of diluting that change in schema experience. It's just another way of keeping the old beliefs going.

Slide 96: Premature Cohesion in Group Therapy

There can also be premature cohesion. The notion is that we're all in this group together. We've all had the same experience. We're all the same. When in fact even if we think of everybody who went through something like Hurricane Katrina or who's been in war, the experiences are very different depending on who's relying on you, what kind of support you have, what your specific exposure was. And so you want to always help people articulate what's the same and what's unique about them as well as what may be comparable and similar in the group.

Slide 97: Phases of Group

The group has four phases. There are group norms, the beginning of, then the development of cohesion, then the work on individuality, and consolidation of gains.

Slide 98: PCGT Format

In the format we're going to talk about here, it's sixteen sessions, ninety minutes each. A typical session involves opening the group, agenda setting, discussion of the main topic and then final review and leave it.

Slide 99: Session 1: Opening the Group

The first session involves opening the group, essentially similar to trauma focus group treatment, setting up guidelines, helping people understand what the objectives of the groups are.

Slide 100: Session 2: Psychoeducation

The second sessions involves psychoeducation, which can actually be pretty straightforward.

Slide 101: Session 3: Psychoeducation

More talk about schemas, how trauma changes schemas, and getting people to talk about the ways they were changed by their experience.

Slide 102: Session 4 & 5: Identification of Issues and Goal Setting

Individuals are then asked to identify personal issues or goals that they would like to work on in the present. Now, they've made a commitment that they're not going to stay in the past and this is an opportunity for them to have the next ten or fifteen weeks to work on current issues.

Slide 103: Sessions 6-13: Discussion Format

That, in fact, is what happens in the bulk of the sessions, that people work on their individual goals. There may be sharing of information. There may also be the kind of transformance among group members that you sometimes see written about in the Yalom's books. But

essentially with attention to interpersonal dynamics really, it's happening on two levels. People are working on their goals while they are also working on the process material in the group.

Slide 104: Sessions 14-16 & Tapering Sessions (4): Consolidation of gains/Time Frame/Sense of Meaning

The final few sessions of the group involve review, consolidating gains, and sometimes referral for other treatment.

Slide 105: Additional Structure for PCGT

Sometimes other things are necessary. You may find out that someone in the group really needs some relaxation, needs some focusing, needs some anger management. This can be added into the group or people can get referrals for additional work.

Slide 106: Critical Therapists Skills for PCGT

If you're going to be a present-centered group therapist, the kinds of skills you need are a comfort with directing people into the present, being very directive about stopping them if they start going into the past, focusing on symptoms and current experience rather than triggers in the past, using grounding techniques, keeping affect at a manageable level, and using the group to assist you.

Slide 107: Treatment Issues for More Recently Traumatized Individuals

Okay, the final part of this talk involves working with recently traumatized individuals. As I said we have relatively little information on what appropriate group treatment intervention approaches would help people who have been recently traumatized. So what we have collected among ourselves and with our colleagues are issues that we think need to be attended to, some advice we might encourage you to consider, but by no means do we think this is the "be all and end all" of the activity.

When we think about treatment issues for more recently traumatized individuals, and particularly as they might apply to group work, first of all-- people have barriers to treatment, it maybe very hard for them to access it. They may not have health insurance. They may not be part of a system like the VA who is going to provide it for them. And they may also have attitudes that it would be scary to get help, or they don't need help, or that it would be a sign of weakness to get help, and so they maybe very resistant to this. When we think about the typical treatment goals for the more acutely traumatized situation, again, we're talking about things like stabilizing the system, preventing family breakdown, preventing social withdrawal, and trying to keep the social network going, helping people in employment, encouraging them not to use alcohol and drugs to manage their difficulties which will then have functional consequences.

Slide 108: Barriers to Treatment Seeking

Obviously there are many barriers to treatment seeking. I'll go into a little bit of detail with that in a moment. But certainly the survivor may have barriers, the family maybe concerned about it, or may not have resources to help. If people have jobs there are often problems with that. I have guys, some of them are reluctant to get assistance because they don't want it to create difficulties at their job. There may be institutional barriers and also just social barriers, groups of individuals who are not well socialized into getting any kind of assistance for psychological issues.

Slide 109: Barriers Likely to be Found in OIF/OEF Veterans

If we think about the kinds of things that might be particularly prevalent with OEF and OIF veterans, the kinds of things we might think about, as I said, is that there may be a stigma of a psychiatric diagnosis, they may have concerns about confidentiality, they may be unwilling to say they have a problem. They may find that there are changes in family dynamics, which are extremely stressful for them and it's not even clear then who's the problem, if in fact they have been on a couple tours in Iraq and their family systems have changed very much while they're away. They may see the way to improve on things by changing their families rather then trying to deal with it themselves, and the family may in fact be evolving and be struggling with these kinds of things. So these are all issues when you're trying to do any kind of treatment, including a group treatment, that are important to attend to.

I want to mention two other things, before I do this summary, things that are also pertinent. One is that there is an issue when you're doing groups, particularly with traumatized individuals: whether in fact you want people who have all had the same event to be in a similar group, or can you mix people? For example can we mix Vietnam era guys with Iraq veterans? Can you mix men and women, those sorts of things?

In a general way, we encourage groups to be as similar as possible in terms of exposure to traumatic events because often times, events can stimulate other members who may not have had personal experience with it or the actual experience of an acute versus a chronic issue can be so different… that we generally think-- if you can get people in who have all had a similar experience that's the better way to go. With one proviso, and this is important. As it turns out, often times because of natural disasters or if National Guard troops are all deployed from one place many people will be back seeking treatment and will know each other [from] prior to the trauma. In our experience that's problematic. People sometimes are reluctant to fully engage in the trauma--in the therapy experience-- if they are concerned about impression management with a neighbor or with a colleague. So, to the extent you can have people in groups who are unknown to each other, that probably will facilitate their work in the group.

Slide 110: Summary of Presentation

The final issue is just to briefly review the material. In summary, PTSD is common, and there's a long tradition of group treatment for PTSD although limited research on it. There is, however, some, and what is available is positive. As we said, you want to match the survivor where they are. This may mean a psychoeducational skills group in the beginning for orientation and then more intensive trauma focus or group treatment later on down the road. That you really need to

be attentive to the fact that as we become a more psychologically sophisticated society we're trying to offer more and more treatment to more and more people who have been acutely traumatized in the recent past. But our understanding about the best way to do that is really still evolving. So generally, the best we can do is be aware of what's worked in the past and then try to use our own best judgment in what we learn from others to try to improve that work as time progresses.

Thank you for attending the talk.